Blue Cross Blue Shield of Rhode Island

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May 4, 2011

Herbert W. Olson
Legal Counsel
Office of the Health Insurance Commissioner
1151 Pontiac Avenue, Building 69-1
Cranston, RI 02920

RE: Proposed Amendments to Regulation 11 – Small Employer Health Insurance Availability Regulation

Dear Mr. Olson,

I am writing on behalf of Blue Cross & Blue Shield of Rhode Island ("BCBSRI") to provide our comments to the Office of Health Insurance Commissioner's ("OHIC") proposed amendments to Regulation 11. Our section-by-section comments are as follows:

Section 5 – Rate Manual and Restrictions Relating to Premium Rates

Section 5(x) requires carriers to provide each employee a Renewal Explanation Form ("REF"). For several years, BCBSRI has voluntarily provided an REF form similar to proposed Appendix J to employers with small group coverage. The percentages displayed in the REF apply to the total cost of premiums that the small group employer will pay, and does not necessarily reflect any changes to the employee contribution (as that element is beyond the control of carriers). Thus, we question whether the benefit of the REF outweighs the expense of creating and distributing an REF to each employee. Instead, we recommend that this section be changed to require carriers to provide the REF to the employer with a request that the employer make the REF available to employees. Alternatively, we request that this section be modified to specify that carriers are only required to provide the REF to subscribers upon their request.

Appendix J depicts the model REF. We have several minor comments on the REF. Paragraph C incorrectly defines the 4:1 rate variation ratio. We recommend that the language be modified so that it is similar to that contained in Section 5(d). We further request the ability to express broker commissions as a percentage of premium instead of dollar amount since the latter would be difficult to capture and requires changes to our systems. Similarly, we do not currently have a mechanism to capture and track broker telephone numbers. We, therefore, ask that the requirement that broker telephone numbers be included on the REF be removed or, alternatively, that it be optional.

Section 6 – Requirements to Insure Entire Group

Section 6(d)(6) references Appendix A that contains model language for explanation of special enrollment rights. We recommend that this Section be modified in order to clarify that such language should be included on the waiver of coverage form.

Section 12 – Annual Filings

I would like to start with a general comment regarding proposed section 12 as it relates to the standard and process for rate filings. We are not aware of a statute that explicitly permits the Commissioner to create, mandate or enforce the rate review process detailed in proposed section 12. Instead, the majority of the proposed changes have been, and are currently, up for debate in proposed legislation (See H 5733, currently before the Legislature) and have been similarly debated in prior sessions. Thus, it would appear that the legislative authority for the proposed regulations is lacking. For a more detailed discussion of the legal basis behind this concern, please see BCBSRI's comments to proposed amendments to Regulation 2, dated May 4, 2011. Since the Commissioner lacks the authority to adopt the rate review process under the principles of administrative law, the proposed amendments to Section 12 should be withdrawn.

Without limiting the issue described above, we make the following specific comments on this section:

Section 12(b)(1) sets forth the date by which carriers must file annual rates. We recommend that this section be modified to read "No later than May 15 each year *or at such other date specified by the Commissioner...*" (changes in italics). In addition, it has previously been recognized by the Commissioner that a carrier may have reason to submit additional rate filings throughout the course of the year, for example, due to changes in factors beyond the control of the carrier (such as the adoption of the Patient Protection and Affordable Care Act) or substantial changes in the solvency of the carrier. It is important that this section be modified to reflect that the carrier may submit additional filings at such times as it deems necessary and that any such filings will be reviewed by the Commissioner in accordance with applicable law.

There are two sections labeled 12(b)(2). The second such section indicates that rates proposed to be charged shall be based on a minimum loss ratio of eighty percent "using a calculation methodology approved by the commissioner." As you are aware, the federal health care reform statute establishes new medical loss ratio reporting requirements. It would be administratively burdensome to require BCBSRI to calculate and report two different loss ratio amounts. Instead, we recommend that this section be modified to read: "The rates proposed to be charged by a small employer carrier shall be based on a minimum projected loss ratio of eighty percent (80%), *using the calculation methodology established under the Patient Protection and Affordable Care Act and implementing regulations*" (changes in italics).

Sections 12(b)(1) through 12(b)(3) sets forth a new process for the annual small group rate filings. We have several concerns with these sections. First, Rhode Island General Laws ("RIGL") §§ 27-19-6, 27-20-6 and 42-62-13 set forth the timing of hearing on rate filings. In addition, the Department of Business Regulation 23 currently sets forth requirements for the filing of forms and rates. The provisions of proposed sections 12(b)(1) through 12(b)(3) appear inconsistent with similar provisions contained in the applicable sections of Regulation 23 and in the relevant statutes. We recommend that OHIC remove the recommended changes or ensure that they conform with applicable statutes and enabling regulations.

Proposed section 12(b)(3)(C) additionally removes the standard of review and replaces it with "the rules and regulations of the Office and any orders issued by the commissioner, or the commissioner's designee." Accordingly, the standard applied to rates may not be known prior to

the filing and is subject to change without notice. Standards used to evaluate a rate filing must be objective, clearly defined, measurable, and consistent across all carriers. Such standards must also be promulgated in accordance with the Rhode Island Administrative Procedures Act, RIGL § 42-35-1, *et seq.* ("APA"). By removing the standard of review, the proposed regulation falls awry of the APA. We ask that any changes to the standard of review comply with the notice and comment requirements of the APA. In addition, such standard must fall within the scope of OHIC's legislative authority.

Section 12(d)(1)(iii) requires a reference to the SERFF filing number for each plan. This provision raises several questions. BCBSRI files our products for approval, not each individual product variation (e.g. we file a HealthMate Coast-to-Coast Subscriber Agreement that reflects the available variations in plan design, such as copayments, coinsurance and deductibles). Furthermore, we file a single set of rates along with a single set of forms that we intend to apply across all of our products in the relevant market. Thus, we seek clarification as to your intent regarding which SERFF filing number would be used. Furthermore, any information filing should require only high-level aggregate information to ensure compliance with state and federal privacy laws. As this section is currently worded, it is unclear the level of aggregation. Please keep in mind that the typical small group plan includes approximately two members. Thus, aggregation on the group or account level would not be sufficient to ensure the privacy of our member's information.

Section 12(e) removes the carrier's right to request confidential treatment of rate filings as allowed under law. RIGL § 27-50-5(h)(3) indicates that all information and documentation required to be submitted by carriers during the rate review process shall be "considered proprietary and trade secret information and shall not be subject to disclosure." BCBSRI objects to any limitation of our right to seek confidential treatment of our rate filing.

Section 13 – Wellness Health Benefit Plan – The HEALTHpact Plan

Proposed Section 13 removes the requirements in year three of the HEALTHpact Plan. BCBSRI recommends that the Commissioner clarify that the requirements outlined in year two of the HEALTHpact Plan apply to subsequent years as well by adding the following language to section 1(d)(2)(C): "Year-two Advantage-level benefits *apply to year two and subsequent plan years and* are tied to the following requirements" (changes in italics).

Thank you for the opportunity to submit these comments. If you have any questions, please feel free to contact me at 459-1122.

Sincerely,

Martha Holt
Assistant General Counsel & Privacy Officer

State of Rhode Island and Providence Plantations

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Peter F. Kilmartin, Attorney General

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Health Insurance
Commissioner

May 5, 2011

Mr. Christopher F. Koller
Health Insurance Commissioner
Office of Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69, First Floor
Cranston, RI 02920

RE: Proposed Amendments to Regulation 11 – Small Employer Health Insurance Availability

Dear Commissioner Koller:

I, as the Attorney General of the State of Rhode Island ("Attorney General") submit the within comments pertaining to the proposed amendments to Regulation 11 – Small Employer Health Insurance Availability.

As the public's advocate in connection with rate filings by insurers, I have particular concerns with respect to the proposed amendments to Section 12 entitled Annual Filings, which are as follows:

> As amended, Section 12 (b) permits the rate analysis conducted by actuarial or other persons with relevant expertise employed by or under contract with OHIC or the Department of Business Regulation to be entered into the record of the Commissioner's review and considered by the Commissioner in a determination relating to approval of any filing relating to small group coverage. It further permits this information to be entered into the evidentiary record of hearing held under the section, **but it does not provide for cross-examination of those individuals consulted or provide** an opportunity to challenge the information they provide as required under the language of the Supreme Court's decision of Arnold v. Lebel. This regulation needs to be amended to permit parties to cross-examine any expert or other individual employed by the Commissioner or the Department of Business Regulation whose opinions are considered by the Commissioner in making a decision as to a rate filing.
>
> In addition, the section does not require the rate filing to be provided to the Attorney General as the public's advocate at the same time it is provided to the Office of Health Insurance Commissioner. This proposed regulation should be amended to provide simultaneous notice to the Attorney General's Insurance Advocate as a matter of fundamental fairness.

I also note that this proposed regulation does not contain reference to the public meetings that you included in your proposed legislative amendments to §42-62-13. To be consistent with your proposed legislation, it would seem appropriate to include language similar to that which will be contained in the amended statute wherein rates would be reviewed in a technical and public meeting context as you have proposed, as well as in a full public hearing under the Administrative Procedures Act.

Further, Section 12 (e) provides that only part of the filing made by the insurer could be available to the Attorney General for review if the Insurance Commissioner has given an express guarantee of confidentiality to the filer. This would deprive the Department of Attorney General as the public's advocate of complete access to the information provided by the rate filer and the ability to fully represent the interests of the public. Moreover, the Attorney General has extensive experience in maintaining confidentiality of documents and information, so there should be no concern as to our office having access to this information. This part of the regulation needs to be amended to provide full access to the Attorney General to the entire filing made by the rate filer in order to provide the public with a full and meaningful opportunity to review and contest any such filing contents.

For the reasons stated above, I respectfully request that the proposed regulations be amended to address and resolve the concerns I have raised above.

Sincerely yours,

Peter F. Kilmartin
Attorney General

Rhode Island Builders Association

Building better communities since 1945

May 5, 2011

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Health Insurance Commissioner

Office of the Health Commissioner
1511 Pontiac Avenue – Building 69-1
Cranston, RI 02920

RE: Comments on Proposed OHIC Regulation 11

The Rhode Island Builders Association appreciates this opportunity to comment on proposed Regulation 11 issued by your office entitled *Small Employer Health Insurance Availability Regulations.* Our comments are limited to the provisions in Section 5(f) & 5(g) regarding proposed restrictions on carriers that provide coverage to the Rhode Island Builders Association (RIBA).

Paragraph 5(f) directs carriers to, "ensure that subscribers in the Builders Association block of business are limited to, those that are "...principally engaged in..." or "...provide a majority of their services to..." persons or entities in the business of "building, repairing, rehabilitating, adding onto, or upgrading homes, apartments and other structures; the repairing, rehabilitating additions or upgrading of property."

Compliance with this section would require that RIBA members participating in the group insurance program demonstrate that more than 50% of their business is generated from the construction industry. This provision is not only onerous and harmful to our association, but it is also inconsistent with the controlling statute (RIGL 27-50-5) and federal regulations governing trade associations.

RIGL 27-50-5 requires only that participating companies be, "actively involved in supporting the construction industry in Rhode Island." While Section 5(e) of the proposed Regulation 11 mirrors that language, the following section (5(f)) raises the participation standard from "actively involved in supporting..." to demonstrating that how they are "principally engaged in" or that they provide a "majority of their services to" construction firms.

RIBA members would have to revise their accounting systems in order to identify and report on qualified business vs. non-qualified business only for the purpose of health insurance participation. Additionally, staff at either the carrier or RIBA would have to review these reports to ensure compliance. Given that there is no statutory basis for this requirement, the time and expense is unwarranted.

We recognize that there is some concern that RIBA could "cherry pick" small businesses in Rhode Island and negatively impact the community pool. This concern is unfounded as federal regulations also limit the membership and activities of the Association.

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RIBA enjoys a tax exempt status as a "Business League" under Section 501(c) (6) of the IRS code. Business Leagues are defined as, "an association of persons having some common business interest, the purpose of which is to promote such common interest and not to engage in a regular business of a kind ordinarily carried on for profit. Trade associations and professional associations are business leagues. To be exempt, a business league's activities must be devoted to improving business conditions of one or more lines of business as distinguished from performing particular services for individual persons."

The elements of this definition are significant in that our tax exemption relies on our membership "having a common business interest" and our activities must be "devoted to improving business conditions" in the construction business. We are further restricted in that our principal business cannot be one that is normally carried on for profit.

The restriction on engaging in business normally carried on for profit is not an absolute prohibition. The IRS considers the level of engagement whether the activity is incidental to "improving business conditions" or it is the primary activity of the association. Activities that remain incidental are taxed on the income derived. For the current fiscal year, RIBA anticipates 7.6% of its gross revenue from health insurance activities. In the previous five (5) years, this activity has averaged 7.9% of total gross revenue. Allocations for staff and overhead would lower that figure substantially.

In short we believe that that "cherry picking" concerns are unfounded as federal regulation limits our membership to those entities "with a common business interest." This is refined by state law as those "actively involved in supporting the construction industry in Rhode Island." Further, federal regulation both limits and taxes our health insurance involvement.

RIBA's membership is made up of a broad spectrum of companies representing the construction industry. In addition to construction companies we also enjoy the support of suppliers and subcontractors, banks and utilities together with industry support professionals such as engineers and real estate lawyers, developers, management and sales firms. The support firms represent slightly under 60% of the total membership. Interestingly, the 300 non-builder companies in our health insurance program represents 59% of the total participation.

Certainly RIBA's non-builder members share a common interest with our builders as they both benefit economically from their business relationships. In addition to dues support, many of these members advertise in our magazine, speak at our seminars, and serve on our committees. By any measure they are "actively involved in supporting the construction industry" but with the exception of the construction trades subcontractors very few provide a "majority of their services" to the construction industry. We have a carpet retailer that provides carpeting and interior design services to many RIBA members. They have been an active participant in RIBA activities for years. They also have a retail business which may or may not provide more than 50% of their revenue. We have an insurance agency that has a sizeable client base of contractors. They also serve other client industries and the public.

They are a valued supporter of our association but probably couldn't pass the 50% test. We have real estate law firms that are active in land use and municipal law and are retained by our land development members but they also have other client bases and probably couldn't pass the 50% test.

What is clear is the 60% or our non-builder membership complies with the statutory requirements and federal regulatory requirements but very few could pass the 50% test that would be imposed by this proposal. As we believe that the concerns that the RIBA group could segment the health insurance market are unfounded we respectfully request that this test be revised to be consistent the state and federal restrictions currently in place on our association. We see no reason for limiting our health insurance activities beyond serving those firms that are, "actively involved in supporting the construction industry in Rhode Island."

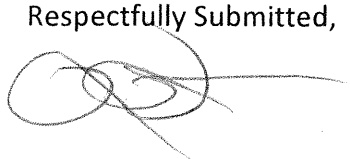
We are also concerned about the language in Section 5(g) which requires carriers to rate RIBA's group "consistent with the purposes of the Act and in a way that will prevent segmentation of the health insurance market." As this language is a reiteration of the Purpose of the Act as it is spelled out in RIGL 27-50-2, we don't see how this adds clarity or what it is intended to accomplish. We believe it can cause further confusion in interpreting the statute particularly the application of 27-50-5(5) to the Rhode Island Builders Association.

Since the implementation of Small Group Reform, RIBA's highest rates have been limited to four (4) times its lowest rate and underwriting adjustments are also limited to age, gender and family composition. This appears to us to be consistent with the purposes of the Act and we question how this would segment the health insurance market. If 27-50-5(5) is interpreted more broadly to allow additional flexibility on the part of the carrier, then we believe that Section 5(g) would be in conflict with this interpretation.

Accordingly, unless its purpose can be clarified, we respectfully request Section 5(g) be removed from the proposal.

We appreciate the opportunity to comment on this proposal and are available to answer any questions you or your staff might have. Both personally and on behalf of the Rhode Island Builders Association my thanks for your consideration of our views.

Respectfully Submitted,



Roger R. Warren
Executive Director

TUFTS Health Plan

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April 27, 2011

Commissioner Christopher Koller
Office of the Health Insurance Commissioner
1511 Pontiac Avenue - Building 69-1
Cranston, RI 02920

Re: Proposed Regulation 11 - Small Employer Health Insurance Availability Regulation

Dear Commissioner Koller:

I am writing on behalf of Tufts Health Plan to offer written comments on the proposed amendments to Office of the Health Insurance Commissioner Regulation 11 - Small Employer Health Insurance Availability Regulation.

Since 1979, Tufts Health Plan has been committed to providing a higher standard of health care coverage and to improving the quality of care its network providers deliver for every member. Tufts Health Plan's Health Maintenance Organization (HMO) plan is ranked number two according to the National Committee for Quality Assurance's (NCQA) health insurance plan rankings.

The proposed changes to Regulation 11 make several amendments to the existing regulation governing the small group market, including changes in rating manual and annual rate filing process, as well as adding a required communication with members. Many of the additions to the rating section of the regulation are currently in force by statute.

Section 5 – Rate Manual and Restrictions Relating to Rates

Subsection (x) of Section 5 requires that carriers provide a "Renewal Explanation Form" to the employees of a renewing employer group, which is "substantially similar to the form set forth in Appendix J". Appendix J lists a numbers of factors that must be included as a part of this form.

It will be a costly and burdensome process to populate and distribute these forms to each employee covered under a Small Group plan. We would recommend that general information – those factors that that apply to all small groups – be posted on the carrier's website along with a phone number that employees could use to get more information on their specific renewal.

While we support transparency, we question whether the proposed level of detail is meaningful to every employee. At a time when reducing costs to the health care system is so critical, we urge you to reconsider this requirement in relation to the administrative burden and implementation costs. Does provision of this information to every employee warrant the additional costs this will add to the renewal process and overall insurance costs.

Tufts Health Plan appreciates the opportunity to comment on the proposed Regulation 11. If you have any questions, please do not hesitate to contact me by email at Kristin_Lewis@tufts-health.com.

Sincerely,

Kristin Lewis

Kristin L. Lewis
Vice President, Government Affairs, Public Policy
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May 5, 2011

Herbert W. Olson
Legal Counsel
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1511 Pontiac Avenue, Bldg. 69-1
Cranston, RI 02920

Re: Proposed Amendment to Regulation 11 – Small Group Health Insurance Availability Regulation

Dear Mr. Olson:

I am writing on behalf of UnitedHealthcare of New England, Inc. and UnitedHealthcare Insurance Company ("UnitedHealthcare") in response to the Notice of Proposed Amendment to Regulation 11 issued by the Office of the Health Insurance Commissioner ("OHIC") (the "Proposed Amendment"). My comments will address proposed provisions in the order in which they appear in the Proposed Amendment.

Section 5 § (w) – Disclosure to groups of one. This section would require carriers to provide groups of one with a current rate sheet for health benefit plans in the individual market. Is this section intended to require only carriers that participate in the individual market to provide individual plan rate sheets to groups of one? If it is intended to require carriers that do not participate in the individual market to provide rate sheets, where will these rate sheets be available? Will carriers be required to present rate sheet for all competitors in the individual market?

Section 5 § (x) – Renewal Explanation Form. This section states that carriers are required to provide the renewal form to "each employee" at the time of renewal of the employer's plan. Was this intended to state that the renewal form should be provided to "each employer"? If to the employees, what value would this be since the premium is charged to the group, not the individual, and each employer has different contribution rates. Employees in different age bands may experience higher or lower rates of increase than what might be disclosed on the form. To comply with this requirement at the individual employee level would be unreasonable and overly burdensome on the carrier.

Section 12 - Annual Filings. This entire section is heavily amended and requires substantial comment. The section appears for the most part to adopt the annual filing process that OHIC

is currently following that was not previously set forth in statute or regulation. One overall objection to the current process is that OHIC has unilaterally changed the filing guidelines from year to year. This results in uncertainty on the part of carriers and prohibits them from properly scheduling the time and resources necessary to address ever-changing requirements, some not disclosed until the filing is imminent. If OHIC wishes to request new information that is not required for its proper review of a rate and trend filing, such requests should be made outside of the review process and not at the same time as the filing. Carriers' compliance with these requests should not be a factor in determining the reasonableness of the carriers' rate and trend submissions.

Section 12 § (b)(1). The template that the Commissioner will specify for any given rate filing should be posted at least 60 days prior to a submission due date. Carriers should be given sufficient time to plan for, gather, test and report the data being required. If the Commissioner determines that a filing requires additional information, notice of the specific missing information must be provided to the carrier within 10 days of the submission. A determination that information is missing should not result in a delay in the rate/trend review timeline unless there is written agreement between the carrier and the Commissioner.

Section 12 § (b)(2). If the Commissioner relies on a written analysis conducted by experts to deny or lower a carrier's requested rates or trends, the Commissioner must provide the substance of that analysis to the carrier at the time of his decision on the rate/trend request.

Section 12 § (b)(2) (duplicate numbered section). The minimum projected loss ratio should be based on the current NAIC methodology to be consistent with federal law and the approach other states, such as MA, have taken.

Section 12 § (b)(3)(B and C). It is assumed that any Orders issued by the Commissioner or his designee will be in accordance with and under the authority of applicable law and regulation. Any delay in the time for making a determination by the designee should require a written agreement of all parties or a certification by all parties on the record of the hearing proceedings. The current language might be interpreted that a delay could be required by a unilateral action of any one of the parties. If the Commissioner conducts the hearing without the appointment of a designee, his decision should be made within eighty days of the date of the filing.

Section 12 § (d)(1)(iii). Informational Filing. The requirement to provide requested data for "each plan issued by the carrier" is unreasonable, arbitrary and exceedingly burdensome on the carriers. It would require an inordinate amount of time, expense and resources to manually develop this information. UnitedHealthcare offers a myriad number of plan designs in the small group market. This requirement would need to be limited to information on a more generic plan level designation, e.g., HMO, POS and PPO plans.

Section 12 § (d)(1)(v and vi). Any "such other information as the commissioner may require" must be reasonable and directly related to the scope and purpose of the annual filing.

Section 12 § (e). Grants of confidentiality must be provided in accordance with existing statute, regulation and case law, not merely at the discretion of the Commissioner.

Thank you for providing us with the opportunity to provide our comments on the Proposed Amendment.

Sincerely,

Philip N. Anderson

cc. Stephen J. Farrell, CEO